REPORT NO 1106/03

ANGUS COUNCIL

SOCIAL WORK AND HEALTH COMMITTEE

9 OCTOBER 2003

MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003

REPORT BY THE DIRECTOR OF SOCIAL WORK AND HEALTH LIAISON

ABSTRACT

The purpose of this report is to inform elected members of the content and implications, as far as they can be established at this stage, of the Mental Health (Care and Treatment) (Scotland) Act 2003 which was enacted on 20th March 2003. The earliest implementation date is likely to be April 2005, though this is still to be confirmed by the Scottish Executive. Codes of practice are due to be published shortly. A copy of the Act will be placed in the members' lounge for information.

1 RECOMMENDATIONS

It is recommended that the Social Work and Health Committee:-

i) notes the contents of this report and the attached appendix;
ii) instructs the Director of Social Work and Health Liaison to bring forward a further report when the Codes of Practice become available.

2 BACKGROUND

The Mental Health (Care and Treatment) (Scotland) Act 2003 (The Act) was enacted on 20th March 2003, following consultation as previously reported (Reports No 753/99 and 578/00). This Act consolidates the many amendments to the '84 Act, but also involves radical changes to procedures in relation to detention and after care provision for people with mental health problems. There are significant responsibilities placed on local authorities to: provide adequate Mental Health Officers to meet the new requirements: to provide after care for people who have been subject to detention and to work in close co-operation with health colleagues to provide an integrated service to people who might be subject to the Act.

The attached appendix sets out the key provisions in the Act, noting in particular where there are implications for local authority services. It should be noted that these issues cannot be fully considered until the Code(s) of Practice becomes available, as these will have a major impact on the way the Act is implemented. These are scheduled to be published this month, though there may well be some delay.

3. IMPLICATIONS FOR LOCAL AUTHORITIES

The implications for local authorities of the Act can be summarised as follows:-

a) the deployment and structure of Mental Health Officer services need to be reviewed to ensure the obligations to provide such services are met;
b) Mental Health Officer training may need to be revisited for those already accredited and will at least need to be updated;

c) there is a clear obligation on local authorities to ensure there are adequate services to meet needs for training, recreation, education and employment of people subject to the Act. This obligation also applies to other departments in the Council;
d) the need to ensure the adequate provision of advocacy services;
e) procedures and guidance will have to be in place to ensure quick access to community care assessments where requests are received;
f) there will be a wider training agenda for community mental health, children's and criminal justice services as all have some obligations under the Act.

4. FINANCIAL IMPLICATIONS

The Financial Memorandum accompanying the Act was published in September 2002 and identified an additional cost of £13 million to local authorities across Scotland on an annual basis. Whether the additional funding will be sufficient to meet the obligation under the Act is unclear. There are significant financial implications in terms of increasing demand on existing services and the need to commission new services, however these demands cannot be quantified until the code of practice is published and clarifies the nature of the local authorities obligations.

5 HUMAN RIGHTS IMPLICATIONS

There are no Human Rights implications arising as a result of the recommendations contained in this report.

6 CONSULTATION

The Chief Executive, the Director of Law and Administration and the Director of Finance have been consulted in the preparation of this report.

7 CONCLUSION

This report outlines the key implications of the new Mental Health (Care & Treatment) (Scotland) Act 2003 for local authorities. It highlights the key new duties and a further report will be prepared for Committee after the publication of the Codes of Practice (by the Scottish Executive) relating to the new Act.

R Peat
Director of Social Work and Health Liaison

NOTE: No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information) were relied on to any material extent in preparing the above report.

APPENDIX

MAIN PROVISIONS AND IMPLICATIONS OF THE MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003

Principles

In common with the Adults with Incapacity Act and other recent legislation, the Mental Health (Care and Treatment) (Scotland) Act 2003 (referred to hereafter as 'the Act') is underpinned by key principles outlined in the first three sections of the Act. These principles must be considered and adhered to in undertaking any interventions using the Act. Briefly these principles are as follows:-

- Past and present wishes of the patient must be considered;
- The views of relevant others, in relation to intended actions must be sought;
- The patients participation in decision-making should be encouraged;
- Adequate information and support (e.g. advocacy) should be provided to encourage participation;
- A range of options should be considered, the chosen option providing the maximum benefit to the patient;
- Equal opportunity of access to treatment should be offered, regardless of the legal status of the patient;
- Services should be anti-discriminatory and culturally aware;
- The minimum restrictions necessary should be placed on the patient;
- The needs and circumstances of any carers should be considered, particularly with a view to provide information and assistance in caring for the patient;
- Where a patient's liberty has been restricted by the Act, there will be a responsibility on the authorities to ensure appropriate services are provided at the time and subsequent to the lifting of any order (known as the reciprocity principle);
- If a patient is under 18 there is a strong emphasis on ensuring any intervention is the best means of securing the welfare of the patient.

These principles present no great difficulties for Angus Council services, as these issues would be considered core to good practice. However there may be training issues to enable staff to demonstrate compliance. The 'reciprocity' principle may have wider implications for the delivery of services, a point revisited later in this report.

Roles and Responsibilities

Significant changes have been brought about in the roles and functions of certain bodies.

The Mental Welfare Commission (MWC) role has been enhanced, in that it will be closely involved in monitoring and reporting on the Act on behalf of the Scottish Executive. There will be a need for increased liaison and communication with the MWC, but the MWC are also responsible for assisting local authorities meet these new obligations (s4 – s20).

The central role of the Sheriff Court under the old act now passes to Mental Health Tribunals. The sheriff court may have a role to play when dealing with mentally disordered persons involved in criminal proceedings, but even in these cases the Tribunals will still have a key role. The Tribunal will consist of three members – a lawyer, a doctor (probably a consultant psychiatrist) and a person with an interest in mental health issues (e.g. mental health professional, user, carer). Mental Health Officers (MHOs) will have to routinely attend tribunals whenever interventions are being sought, amended, reviewed or revoked. Due to the more 'inclusive' approach of the tribunals there are likely to be more participants and it has been suggested these could routinely last for 2 to 3 hours. This clearly has time implications for MHOs. (s21 and Schedule 2)

The roles of local authorities and health bodies has been enhanced but not significantly changed. MHOs continue to be central to the consent and assessment/care planning processes and are still to be appointed by local authorities from suitably trained and experienced social workers.

Named persons

Previously the nearest relative was central to many parts of the Act and had certain powers to consent, appeal or object to the imposition of orders, or to request that orders are sought. The new Act significantly changes this position. At the age of sixteen an adult can nominate a 'named person', by signing an appropriate document, who will be kept informed about any measures being taken under the Act, given appropriate information and have the opportunity to be heard at tribunals. If there is no named person the patient may be able to nominate someone if they have sufficient capacity to do so at the time. If not, then the primary carer should be treated as the named person and if there is none, only then will the nearest relative be treated as 'named person'. Consent to detention or other compulsion will only be given by a MHO. A named person will be able to seek an assessment of need to which authorities are bound to respond, if not actually assess (this matter is covered later in the report).

The main problem with this issue for local authorities is that it is the MHOs job to identify the named person. If the person was nominated some time ago the whereabouts of the documentation may be unclear. It could become complicated deciding on who is the primary carer. The Code of Practice will hopefully give guidance on these matters. Local authorities will become the 'named person' for young people under sixteen who are in their care or over whom they hold parental rights. (Part 17 s250 –s273).

Advocacy

The Act introduces an enhanced role for advocacy services. It is clearly anticipated that advocates could be involved in many aspects of the detention/compulsion processes and are likely to routinely attend tribunals. Health boards and local authorities are obliged to collaborate in ensuring that there is sufficient availability of advocacy services to meet the needs of persons who may be subject to the Act in their areas. This has significant implications locally as advocacy services are not adequately placed to meet these demands and there will have to be agreement between NHS Tayside and Angus Council as to how these services will be enhanced (Part 17 s250 –273).

Service Provision

Part 4 sets out the duties of health boards and local authorities. This includes ensuring adequate numbers of approved medical staff and MHOs are available. For health boards there are new responsibilities in terms of providing appropriate services and accommodation for in-patients who are under 18 or who are mothers of young children. This will have implications locally for the configuration of health services.

This duty on local authorities is potentially significant. The reciprocity principle has particular application here. The local authority must ensure services are provided to offer: care and support; to promote well-being and social development and to assist with transport relevant to these services. The range of services referred to includes leisure, recreation, training, education and employment. This will have implications for other departments in Angus Council, in making their services more accessible. It is also made clear that these services, in line with the principles, should be available to all who have a mental disorder whether or not they are subject to compulsion and may also have to be available to in-patients. There will need to be an assessment of local provision of this kind and additional services will undoubtedly require to be commissioned.

Additionally there appears to be an obligation on local authorities to investigate circumstances where a person who has mental disorder may be at risk, though it is unclear how far this extends beyond duties under the old act or the Social Work (Scotland) Act 1968. The code of practice should clarify this matter.

This part also exhorts local authorities and health boards to co-operate in discharging these functions. Given the advanced stage of integrated working in Angus, this should be less of a difficulty than in some other areas. (Part 4 s22 – s35)

Assessment of need

Under Part 14, health boards and local authorities have a duty to carry out assessments on persons where mental disorder appears to be a factor, on request from the person themselves or from the patients 'named person'. A written response must be sent within 14 days indicating an intention to carry out the assessment or giving reasons why an assessment is not to be carried out. This could have significant implications for the workload of community mental health services and will require robust internal procedures to ensure such requests reach the appropriate team within the required timescales. There are also questions over the rights of individuals to refuse to be assessed. Training and guidance will be essential for staff involved in these processes (Part 14 (s227 – s228).

Civil Compulsion Measures

Parts 5,6,7 and 9 of the Act deal with compulsory measures, from emergency detention (72 hours) and short term detention (28 days) to longer term compulsory measures which may be applied to detain someone in hospital or to reinforce provision of community services. Superficially these measures seem similar to measures under the old Act, however there are essential differences in process, particularly with regard to the roles of tribunals, patient representatives and the MHO. MHO consent is an absolute requirement, except in the case of emergency detentions and even then there is a very strong expectation that MHO consent will be obtained. In Angus the practice of MHO consent wherever possible is well established and there are adequate numbers to meet current obligations

There is an expectation that the same MHO will follow through different compulsion processes with a patient, requiring some liaison with out of hours services, though again this practice is well established in Angus.

MHOs will have to undertake more written reports, which will require to be more detailed, in particular naming persons involved in providing after care and specifying details of these services. This is less of a problem in Angus as the practice has always been to provide reports for consultants and for the courts.

Until the code(s) of practice are published the intended workings of these orders are unclear, but the practice will be underpinned by the principles already outlined and it is likely that care planning and monitoring systems will have to be much more robust.

Although as stated Angus Council MHOs should be well placed to meet these new obligations, there is no doubt there will be a significant increase in time spent on MHO work. As all MHOs undertake this role in addition to their role as care manager/social worker there are implications for workers having sufficient space to manage MHO work and the caseload from their team base. Given the fact that MHO training is a drawn out and expensive process numbers, deployment and workloads of MHOs should be closely monitored under the new Act and issues of recruitment and retention should be considered. Consideration may also need to be given to the re-training of existing MHOs, though the Scottish Executive has given a commitment to producing comprehensive training materials well before the implementation date. (Parts 5,6,7,and 9)

Mentally disordered persons and criminal proceedings

Parts 8,10,11,12 and 13 deal with various aspects of the above. Significant amendments are made to the Criminal Procedures (Scotland) Act 1995. Assessment orders and treatment orders are created by the Act. Compulsory Treatment Orders are also created and are similar in effect to civil orders, however restrictions can also be imposed. A comprehensive range of measures has been set out that apply from arrest and pre-trial to eventual disposal.

Many of the duties within the Act will fall to medical staff and the court service. However there are times when MHOs will have to be involved and clearly criminal justice staff will have to be familiar with this part of the Act, so there are training needs arising from these parts of the Act. It should also be noted that the 'reciprocity' principle applies to actions under this part of the Act and consideration will need to be given to making services available to this group, who may be difficult to engage and may have special educational and learning needs. (Parts 8,10,11,12,and 13).